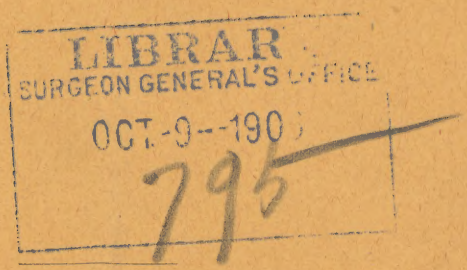
HIRST (B.C.)

PUERPERAL PHLEBITIS.



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PHILADELPHIA.

1894

Reprinted from THE MEDICAL AND SURGICAL REPORTER December 22, 1894.

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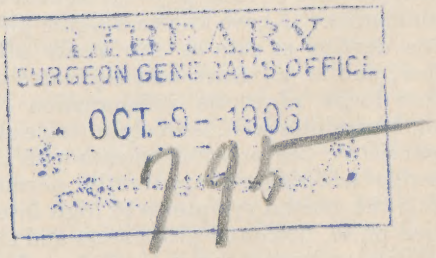

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PUERPERAL PHLEBITIS.*

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Of all the forms that sepsis can present in a woman after labor, phlebitis, I should say from experience in consulting practice, is least understood, most often mistaken for something else and most frequently maltreated by the general physician. And yet there is no form of sepsis that has so many distinctive and peculiar characteristics if they are known and looked for. The most misleading features in the disease, from a diagnostic point of view, are the late appearance of symptoms and the entire absence of local physical signs of inflammation. I have known a septic phlebitis develop as late as five weeks after labor, and in all cases uncomplicated by other forms of septic inflammation the womb involutes well, is freely movable and insensitive; the broad ligaments with the uterine adnexa are apparently normal, while the general symptoms of high fever, rapid pulse, profound prostration and metastatic developments may be most marked. It is this absence of local symptoms that strengthens the indisposition in us all to admit sepsis as the cause of disease in our patients after childbirth.

Symptoms.—A typical clinical picture of puerperal phlebitis presents the following characteristics: Evidence of disease appears ten days or more after confinement; there may have been a slight evening rise of temperature from the beginning of the puerperium, and during this time the patient may have appeared somewhat restless or anxious with a flush on one or both cheeks; the pulse also may have been somewhat accelerated, but there is scarcely enough in the woman's condition to attract her physician's attention. After a varying but considerable length of time, with the premonitory symptoms just described or with none at all, the temperature rises high in twenty-four or forty-eight hours, a chill sometimes but not usually preceding the fever. The pulse is rapid out of all proportion to the temperature, there is a dusky flush on the cheek or cheeks and patches of red may appear on other parts of the body, particularly on the chest. The tongue is very foul. The patient has an anxious, troubled, restless look, but if questioned may reply that she feels perfectly comfortable, or if she feels ill she cannot complain of any localized pain or discomfort. The abdomen is not distended nor is it usually at all sensitive to pressure. A vaginal examination is entirely negative. The disease once begun runs a most tedious course. I have attended two patients who were seriously ill, with high fever for four months, and I think the woman lucky whose illness is not protracted beyond three weeks. Another most distinctive feature in the course of the disease is the tendency to complete remission of the fever and of all other symptoms for more than a week perhaps; then there is a recurrence of high fever, rapid pulse and profound prostration—in short, a reappearance of all the old symptoms in their original intensity, but the relapse does not often last long. I have seen such a

*Read before the Philadelphia Obstetrical Society.

relapse recur three times in an individual who had been ill three months before the first remission.

Complications.—As is well known, the commonest complication of phlebitis is phlegmasia, but the latter is by no means a necessary consequence of the former. I have seen many a case run its course without a swelling in the leg or legs and a number of cases besides in which the phlegmasia was a transitory, scarcely noticeable phenomenon in the course of the disease. Phlegmasia is too large a subject to consider here, and I shall simply refer to some interesting features of it that have struck me in my own experience. I have the notes of sixteen cases seen in private, consulting and hospital practice. In two instances there was double phlegmasia. In one case the swelling first appeared seven weeks after childbirth. In two cases there was a combination of the cellulitic and of the thrombotic phlegmasia. In one case there was an abscess in the popliteal space; in another, in the calf of the leg. In several cases the phlegmasia began as a pure pressure thrombosis, but in all these cases the clot eventually became infected and there was some septic fever.

It is a fact not generally appreciated that the thrombosis of phlebitis in the puerperium is not necessarily confined to the veins of the pelvis and to those of the lower extremities. Large veins far distant from the seat of original infection may be affected. As an illustration, my friend Dr. Fussell has told me of a woman under his charge in whom the longitudinal sinus of the brain was found solidly blocked by a well-organized antemortem clot. She died four weeks after confinement, death being preceded by coma and convulsions.

Another well-known complication of septic phlebitis is a metastatic septic inflammation anywhere in the body. The brain, the eyeballs, the lungs, the pleura, the kidneys, the liver, the spleen, the subcutaneous connective tissue may be the seat of an abscess. I have seen in a puerpera the whole of one leg and a forearm riddled by the multiple abscesses of suppurative cellulitis.

Still another complication is profuse hemorrhage from the veins of the placental site. One of my students has recently told me of a case in which there were repeated alarming floodings in the course of a puerperal phlebitis, following attempts at intra-uterine disinfection.

Treatment.—The treatment of puerperal phlebitis is summed up in a short sentence: Abstention from local interference and the freest possible use of stimulants and food. Any attempt at intra-uterine disinfection will make the patient distinctly worse. There is imminent danger of causing metastases or hemorrhage by local interference. In one of my patients an intra-uterine douche was followed by a chill, aud within twenty-four hours by suppurative pleurisy. In another the temperature rose to 106.8° after cleansing the uterine cavity. This indeed is a diagnostic feature of considerable value, and is occasionally the only way to distinguish between sapræmia and phlebitis, as the following clinical history proves: I saw in consultation a lady who had been delivered three weeks before. She had had a temperature of about 103° for two weeks; her pulse was rapid; there was profound prostration, and one of the most distinguished physical diagnosticians of Philadelphia had the day before detected an incipient septic pneumonia. The abdomen was flat and not tender. The uterus was well involuted and perfectly movable. There was a slight bloody discharge without odor. All this looked very much like phlebitis. I thoroughly disinfected the uterine cavity, however, and within twelve hours the temperature fell to normal, the signs of pneumonia disappeared and the patient made an uncomplicated recovery. Had this case been one of phlebitis, as it seemed to be, my local interference would have made the woman much worse. But in spite of this risk I always carry out one thorough disinfection of the womb, even in a case in which I feel pretty certain of the diagnosis of phlebitis. The clinical history just related is sufficient for such a rule of practice. Having established the diagnosis of phlebitis and having shown the futility of local disinfection, my routine treatment is as follows:

Milk, predigested if necessary, and predigested beef at regular intervals and in as great quantities as the patient can digest; whisky, as near a pint a day as she can stand; or, if necessary, champagne in larger quantities. Digitalis for the rapid pulse and quinine and iron by the bowel.

The patient is kept in bed for at least ten days after all symptoms disappear.

Prognosis.—In spite of alarming symptoms and long continuance, the disease should end in recovery in the vast majority of cases. I have only lost one of my cases of phlegmasia and two other cases of phlebitis, a mortality of about 10 per cent. Among the women who recovered were some as desperately ill as I ever saw, so that I approach a case of this kind with considerable confidence as to the result.